OFFICE OF
THE
CHIEF MEDICAL EXAMINER

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HISTORICAL BACKGROUND

(Coroner System - Medical Examiner System)

The Medical Examiner and the Medical Examiner system has evolved from duties which were assigned to Coroners and systems put in place to effect the legislated and non-legislated responsibilities of the office.

The word coroner is a derivation from the old French spelling of the word "crown". The office of "Crowner" (crown representatives) was originally established to secure revenues which accrued to the crown in the event of sudden or unexplained deaths.

The first detailed statute on the office of coroner was the 1275 Statute of Westminster which established the office for revenue purposes. Subsequent British legislation shifted the Coroner's responsibility to the investigation of deaths due to violence or unnatural means but retained the revenue aspect through a fee payable to the Coroner for each inquest held.

Historically, Canada inherited the concepts of a Coroner and of a Coroner's inquest as part of the common law. The common law powers of a Coroner to indict persons upon an inquisition for murder or manslaughter, to commit them for trial and to certify evidence were incorporated as part of the Canadian Criminal law in 1892, at which time the indictment function of the inquest was terminated.

The subsequent enactment of Provincial legislation established the jurisdiction and role of the Coroner and continued the Coroner's functions of investigating deaths, empanelling juries and conducting inquisitions (inquests). In some provinces and territorial jurisdictions the Coroner concept still remains.

With the advancement of the Forensic Sciences and Pathologists specially trained in Forensic Medicine, it seemed logical that with a bulk of reportable cases being medical in nature that instead of reporting to Lay Coroners, that the reporting be done to qualified medical persons. From this evolved the Medical Examiner System.

It was as recently as 1971 that Manitoba enacted and proclaimed THE FATALITY INQUIRIES ACT to replace THE CORONER'S ACT. This statute was reenacted in 1975 and again in 1987 and remained in effect until May 14 th, 1990, when a new FATALITY INQUIRIES ACT was proclaimed.

The distinct features of the current Act are the division of responsibilities into the medical and legal disciplines; the initial inquiry into the cause and manner of death being carried out by a duly qualified medical practitioner; and the inquest, when deemed necessary, being conducted by a Provincial Judge without a jury.

This brief historical background has been provided to explain that in Manitoba the Medical Examiner system, while relatively recent in origin, has been both legislatively and operationally implemented and has fully replaced the Coroner system.

INTRODUCTION

The Office of the Chief Medical Examiner in Manitoba is responsible under the Fatality Inquiries Act and Vital Statistics Act for the inquiry/investigation and certification of all deaths by violence, as well as unexpected, unexplained or unattended deaths. Certain hospital and institutional cases, notably those of persons dying within ten days of surgery or anaesthesia, or within 24 hours of admission, are investigated, as are deaths of persons held involuntarily, and residents of personal care homes. Also, in the event of the death of a child-in-care the Chief Medical Examiner shall review the actions taken by the Child and Family Services agency.

The area of jurisdiction is the province of Manitoba, which has a population of approximately 1.1 million. In addition, the Medical Examiner has jurisdiction over those who travel through the province.

The Medical Examiner system, under the direction of the Chief Medical Examiner, is managed from a central office located in Winnipeg. The office administers the complete province of Manitoba and has a permanent staff of one administrative officer, five medical investigators, and three administrative secretaries. The fee-for-service element is provided by 75 part-time medical examiners with additional fee-for-service support provided by pathologists, funeral directors and ambulance services.

In the City of Winnipeg, medical investigators are on duty and available 24 hours per day. Part-time medical examiners are also available through a rotating duty roster system.

Throughout rural Manitoba and in other cities such as Brandon, Thompson, etc., part-time medical examiners are available on an as-required basis 24 hours a day. Toxicology testing is provided by the Royal Canadian Mounted Police Forensic Laboratory. Other speciality tests are provided on an as-required basis, utilizing outside resources both in and out of the province of Manitoba.

In 1990, 2633 deaths were investigated by the Chief Medical Examiner's office. This represented Thirty percent of all deaths in Manitoba during the year. In each case, the report generated by the medical examiner or medical investigator contained information on the cause, manner, identity and age of the deceased, and circumstances surrounding the death. In many cases the police, both RCMP and municipal forces, assist the medical examiners in conducting their investigations.

In January of 1985, the Office of the Chief Medical Examiner became actively involved in the eye donor program. Next of kin were contacted shortly after death and asked to consent to donating the cornea of the deceased. Through the program, regular donations were made available to the Lions Eye Bank.

Appreciation is expressed to all Law Enforcement Agencies and all other related agencies involved who have throughout the year, cooperated and assisted in the investigations which have been processed through this office. Also, gratitude is expressed to all Medical Examiners who, frequently under adverse conditions, have shown a high level of dedication, and professionalism.

Caseload Statistics 1990

TOTAL CASES

CERTIFIED CASES

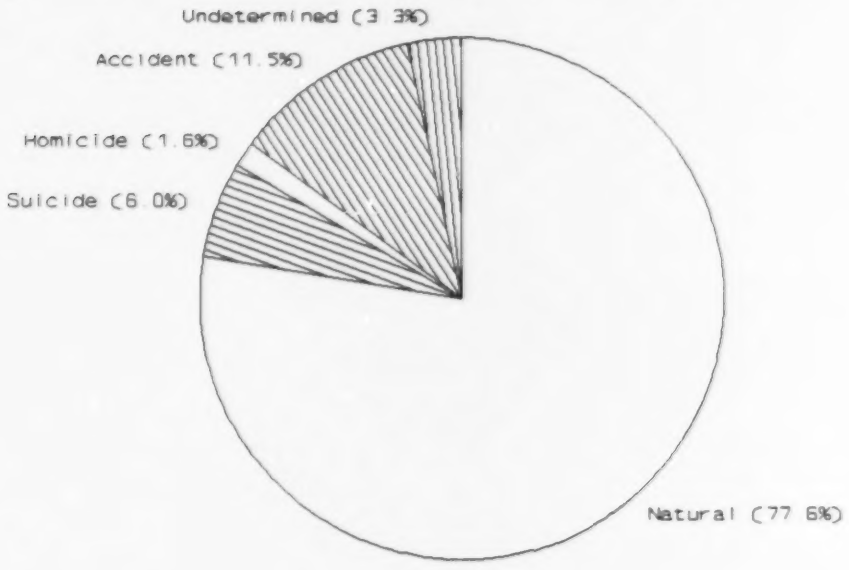
Manner of Death	Cases	Aggregate Rate per 100,000 of Population
Natural	2043	187.2
Accidents:		
In the Home	81	7.4
In Other Places	57	5.2
Industrial	24	2.2
Motor Vehicle	142	13.0
Suicides	158	14.5
Homicides	41	3.8
Undetermined	87	8.0
Total	2633	241.3

Note: 573 Natural deaths were designated Medical Examiner's Investigators cases.

REGIONAL DISTRIBUTION OF CASES

	Urban	Rural	Total
Natural	1617	426	2043
Accidents:			
In the Home	44	37	81
In Other Places	19	38	57
Industrial	6	18	24
Motor Vehicles	54	88	142
Suicides	97	61	158
Homicides	27	14	41
Undetermined	64	23	87
TOTAL	1928	705	2633

MEDICAL EXAMINER CASES



CASELOAD REVIEW 1973 - 1990

YEAR	TOTAL
1973	2409
1974	2409
1975	2604
1976	2653
1977	2758
1978	2667
1979	2627
1980	2480
1981	2683
1982	2480
1983	2545
1984	2386
1985	2522
1986	2605
1987	2503
1988	2541
1989	2582
1990	2633

TYPES OF DEATH
INVESTIGATED AND CERTIFIED

HOMICIDES

	Male	Female	TOTAL
Urban	16	11	27
Rural	10	4	14
TOTAL	26	15	41

AGE / METHOD

Method Age:	**0-9**	**10-19**	**20-29**	**30-39**	**40-49**	**50-59**	**OVER 60**	**TOTAL**
Firearms	0	2	4	3	0	1	1	11
Blunt Weapon/ Violence	0	1	4	2	3	0	2	12
Stabbing/ Incised Wound	0	2	4	3	0	0	0	9
Police	0	0	0	0	0	0	0	0
Child Battery	3	0	0	0	0	0	0	3
Other	1	2	0	1	1	0	1	6
TOTAL	**4**	**7**	**12**	**9**	**4**	**1**	**4**	**41**

SUICIDES

SEX AGE:	10-19	20-29	30-39	40-49	50-59	60-69	70-79	> 80	TOTAL
MALE									
NON-NATIVE	7	21	25	19	12	5	5	3	97
NATIVE	7	12	5	1	0	0	0	0	25
FEMALE									
NON-NATIVE	0	9	10	3	2	3	1	1	29
NATIVE	1	4	1	1	0	0	0	0	7
TOTAL	15	46	41	24	14	8	6	4	158
RATE/100,000 POPULATION	1.4	4.2	3.8	2.2	1.3	0.7	0.6	0.4	14.5

REGION / MONTH

Month of Death	Urban	Rural	TOTAL
January	7	4	11
February	6	6	12
March	4	9	13
April	13	4	17
May	13	6	19
June	7	5	12
July	8	5	13
August	8	8	16
September	7	5	12
October	9	3	12
November	5	3	8
December	10	3	13
TOTAL	97	61	158

SUICIDE RATES PER 100,000 POPULATION OF MANITOBA BY YEAR

YEAR	Estimated Population (000's)	Total Suicides	Rate per 100,000 of Population
1973	996.2	124	12.45
1974	1007.5	141	14.00
1975	1013.6	141	13.91
1976	1021.5	141	13.80
1977	1027.4	179	17.42
1978	1032.0	155	15.02
1979	1028.3	135	13.13
1980	1024.9	126	12.29
1981	1026.2	151	14.71
1982	1034.5	149	14.40
1983	1048.1	172	16.41
1984	1058.8	151	14.27
1985	1070.6	141	13.17
1986	1071.2	168	15.68
1987	1080.3	172	15.92
1988	1084.0	175	16.14
1989	1084.8	158	14.56
1990	1091.6	158	14.47

METHOD

	Male	Female	Total	Percentage of Total
Drug overdose/Poison	12	16	28	17.7 %
Carbon Monoxide	23	7	30	19.0 %
Hanging/Strangulation	40	4	44	27.8 %
Drowning	1	2	3	1.9 %
Firearms	41	2	43	27.2 %
Jumping	2	3	5	3.2 %
Other	3	2	5	3.2 %
TOTAL	122	36	158	100 %

NATIONAL SUICIDE RATES PER 100,000 POPULATION OF CANADA 1980 - 1990

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
National Rate	14.0	14.0	13.9	15.1	13.7	12.9	14.5	14.0	13.5	13.3	N
NFLD	3.4	4.2	6.0	6.2	6.7	4.0	4.0	4.9	7.7	5.1	O
PEI	11.4	7.4	8.9	12.9	12.0	3.6	11.1	8.6	10.1	8.5	T
NS	11.5	10.9	12.2	12.1	9.9	12.0	10.8	12.6	12.0	10.9	
NB	11.6	11.1	12.9	14.2	12.6	12.0	13.5	10.5	15.1	11.7	A
QUE	14.8	16.4	16.5	18.5	15.7	17.1	17.6	17.9	16.4	15.6	V
ONT	13.1	12.5	12.7	12.9	12.3	11.4	12.4	11.5	11.1	11.9	A
MAN	11.8	14.0	13.4	15.8	12.7	11.9	14.3	15.8	14.2	14.6	I
SASK	15.9	17.7	17.5	14.9	13.5	13.0	13.7	13.0	14.3	12.3	L
ALTA	18.1	15.9	16.2	16.7	17.2	12.6	17.9	16.1	16.7	14.9	A
BC	14.8	14.5	15.0	14.8	13.4	10.4	14.7	14.1	12.7	13.7	B
YUKON	50.0	22.0	29.0	36.0	23.0	35.0	43.0	28.6	27.8	19.8	L
NWT	20.0	22.0	17.0	43.0	34.0	25.0	29.0	28.9	40.2	58.2	E

Source: Statistics Canada

TRAFFIC ACCIDENTS

Motor Vehicle

- Alcohol related	59
- Alcohol report not done	42
- Not alcohol related	41
TOTAL	142

Vehicle/Pedestrian	24	Vehicle/Train	1
Vehicle/Vehicle	52	Vehicle/Fixed object	0
Single vehicle	45	Multiple vehicle	0
Snowmobile	5	Motorcycle	4
All terrain cycle	3	Vehicle/Motorcycle	2
Minibike/Off road	0	Vehicle/Cyclist	4
Motorhome	0	Other	1
Recreational vehicle	1		

TOTAL TRAFFIC FATALITIES 142

NON-TRAFFIC ACCIDENTS

A. INDUSTRIAL

Farming	9
Mining	1
Other	14
TOTAL	24

B. IN OTHER PLACES

Aircraft	1
Exposure	11
Drowning	18
Carbon monoxide poisoning	1
Falls	6
Hunting	0
Falling objects	4
Other	16
TOTAL	57

C. IN THE HOME

Falls	21
Asphyxia	7
Inhalation burning house	24
Burns/Scalding	2
Electrocution	1
Drugs/Alcohol	15
Inhalation (Sniffing)	0
Cafe Coronary	1
Other	10
TOTAL	81

Total non-traffic accidents	**162**
TOTAL ACCIDENTAL DEATHS	**304**

NATURAL DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Heart Disease	676	407	1083
Cancer	87	64	151
Lung Disease	131	84	215
Haemorrhage	112	90	202
Intra - Operative	5	6	11
Post - Operative	112	83	195
Stillborn	2	1	3
Undetermined	10	8	18
Other[1]	81	82	163
TOTAL	1216	825	2041

AGE GROUP	MALE	FEMALE	TOTAL
Still born	3	3	6
Under 1 year	14	13	27
1 - 9	2	8	10
10 - 19	5	0	5
20 - 29	13	8	21
30 - 39	31	11	42
40 - 49	53	29	82
50 - 59	147	40	187
60 - 69	300	160	460
70 - 79	362	256	618
80 - 89	260	220	480
90 - 99	22	72	94
over 100 years	1	3	4
unknown	3	2	5
TOTAL	1216	825	2041

[1]Excluded from total are two separate cases of a fetus where the sex could not be determined.

REPORTS ON CHILDREN - IN - CARE AT TIME OF DEATH

YEAR	MALE	FEMALE	TOTAL
1987	4	7	11
1988	9	3	12
1989	13	9	22
1990	11	12	23

SUDDEN INFANT DEATH SYNDROME

Age Group	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
O - 4 Months	0	3	2	2	0	1	1	0	1	1	4	2
5 - 8 Months	1	0	1	1	1	0	1	0	0	0	2	0
9 - 12 Months	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1	3	3	3	1	1	2	0	1	1	6	2

In Manitoba S.I.D.S. accounted for 24 infant deaths in 1990. The overall incidence of S.I.D.S. has been reported as 1 case per 1000 live births. Although it can occur at any time during the first year of life, the peak incidence in Manitoba is during the first four months.

S.I.D.S. STATISTICS 1977-1990

1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990
34	24	21	23	34	22	28	22	23	22	13	17	21	24

UNDETERMINED[2] DEATHS

CAUSE OF DEATH	MALE	FEMALE	TOTAL
Asphyxia	0	4	4
Carbon monoxide poisoning	4	0	4
Drowning	1	2	3
Drugs/Alcohol overdose	8	13	21
Falls	7	1	8
Exposure	1	0	1
Other	13	9	22
TOTAL	34	29	63

[2]Undetermined as to whether death was a suicide, homicide or an accident.

INQUESTS

INQUESTS SUMMARY
(January 1, 1990 - December 31, 1990)

Judicial Recommendations For the Prevention of Similar Deaths

Manner of Death	Given	Not Given	Not Available
Natural	0	2	1
Homicide	0	0	0
Suicide	3	0	0
Accident	5	4	2
Undetermined	0	0	0
TOTAL	8	6	3

TYPE OF INQUESTS

A. HOSPITAL/INSTITUTIONAL RELATED

Undetermined	0
Accidental	1
Suicide	1
Natural	0
TOTAL	2

B. OCCUPATIONAL RELATED

Accidental	7
TOTAL	7

C. POLICE/INCARCERATION RELATED

Suicide	2
Undetermined	0
Accidental	0
Natural	2
TOTAL	4

D. SPORTS/RECREATIONAL RELATED

Accidental	1
TOTAL	1

E. OTHER

Homicide/ Suicide	0
Undetermined	0
Accidental	2
Suicide	0
Natural	1
TOTAL	3

TOTAL INQUESTS: 17

Summary of Inquests and Recommendations

(All deaths occurred in 1990)

Case	Description	Judicial Recommendations
1. Drowning - Asphyxia	*Accidental: Deceased was operating a D6 Caterpillar on Wintering Lake, clearing a winter road, when the machine went through the ice. The deceased went down with the machine. Death was a result of drowning.*	*1. The wearing of life jackets or floatation suits by all individuals involved in clearing winter roads.* *2. The installation of an escape hatch on the equipment, in the event the equipment breaks through the ice, to enable operators to disengage themselves from the machine as quickly as possible. In the event of heavier equipment such as tractor crawlers (D4, D6 etc.) being employed, it should be required practice that the canopy be removed while the machine is on the ice. Due to the extreme weight of these machines, even an escape hatch will not assist an operator should the machine go through the ice. Evidence at the inquest indicated that the machine would drop so quickly that the operator has little or no time to take evasive action, as was the case here. It is recommended that such heavy equipment have an open top.* *3. The installation of outriggers on equipment to slow their descent or possibly prevent their breaking completely through the ice.* *4. Mandatory and extensive training for all individuals involved in clearing winter roads so that everyone is aware of required safety procedures, minimum ice thickness requirements, type of equipment required and other like matters.* *5. The government should impose mandatory requirements as to procedures to be used and the type of equipment to be employed for the opening and maintenance of winter roads. At the present time, no such requirements exist and the type of equipment used is at the discretion of the contractor. This practice should cease and strict guidelines should be imposed by the government.* *6. An investigation should be undertaken into the present practice of requiring mandatory opening dates for winter roads. Evidence at the inquiry indicates that at certain times the ice may not be in a suitable condition for opening a winter road by the required date. The only criteria for opening a road should be the condition of the ice. The decision to open a road cannot be*

Case	Description	Judicial Recommendations
		based on time conditions at the expense of safety. *7. Numerous examples were given as how the use of radios to allow communication between individuals improved safety conditions. This evidence at the inquiry indicates that it is vital to have two way radio communication between all those individuals involved in clearing a winter road.* *8. There should be more supervision and attention paid to the types of vehicles using the roads and have weight limits implemented.*
2. Hanging	*Suicide: Deceased was an inmate at the Provincial Remand Centre when he was found hanging in his cell by the neck by means of a ripped bedsheet. No previous indications of suicidal tendencies.*	*1. Given the very nature of the institution, the volume of inmates that pass through it (approx. 10,000 per year), and the fact that approximately two-thirds of the same represent some level of suicide risk, it is particularly important that the admissions process be carried out entirely by trained and experienced Remand Centre staff and that the Escort officers, who apparently now play substantial role in the admissions process, be given a much lesser role in view of the fact that an inmate may very well feel some hostility towards these individuals who are perceived by him to have played a role in removing his liberty, and as a result, that inmate is much less likely to impart relevant information to these officers which may affect his safety during his stay at the institution.* *2. That all staff should be aware of the backgrounds of the inmates to improve the sensitivity towards them. This information must be kept confidential or it might bring pressures to bear on the inmate.* *3. That the new system being tested state the importance of asking risk-information be transferred with a prisoner who is transferred from one institution to another and secondly that the inmate tracking system, which would contain relevant information such as suicide ideation and discipline problems, would allow for greater knowledge as in to the state of the inmate.* *4. That a system be set up such that the Remand Centre be divided into units and an officer assigned to one unit. This would allow for more contact between the inmates and officers.* *5. At the time of the deceased's death psychiatrists where only available on part-time basis.*

Case	Description	Judicial Recommendations
		Which with the back load of prisoners priorities were given to inmates who asked for assistants. It would appear that there is a very real necessity for ensuring psychiatrists are more readily available to the needs of the inmate population at the Remand Centre. *6. The theme 'that all staff are aware that they have a responsibility and duty towards the prevention of suicide. A potential suicide risk cannot be just considered a psychiatric problem' be used in drafting new staff policies.*
3. Coronary thrombosis -	*Natural: Deceased had previously been admitted to hospital from a car accident. He signed himself out and was taken to the police department. He was left alone in an holding room and an hour later found expired on the floor. Also contributing to death was aspiration of gastric contents.*	*None.*
4. Journeyman/Lineman - Electrocution	*Accidental: Deceased was a Manitoba Hydro employee who while doing routine maintenance work, accidently came in contact with a high voltage power line electrocuting himself.*	*Not available.*
5. Crushing Injury to the Head	*Accidental: Deceased was playing badminton on the upper stage of the gymnasium when he knocked a metal folding table and a loose wheel fell off and the 300 pound table fell on top of the deceased. Deceased had Down's Syndrome.*	*None.*
6. Asphyxia - compression of umbilical cord	*Natural: Deceased was being delivered at home by two midwives who did not recognize when complications*	*None.*

Case	Description	Judicial Recommendations
	occurred and finally the mother was taking to the hospital where deceased was stillborn.	
7. Multiple injuries from fall	*Accidental: Deceased, with 12 years of experience in such work, was dismantling a grain elevator and storage system for moving to another site, in the middle of moving a large piece of unstable equipment, 105 feet from the ground, he was propelled into a transformer on a hydro pole and then fell to the ground. Death was instantaneous from multiple trauma.*	*None.*
8. Massive Heart Attack	*Natural: Deceased was found expired on the floor of a holding cell. He had a history of anginal attacks, and extensive damage from heart disease and hypertension.*	*Not available.*
9. Multiple injuries from collision with a vehicle	*Accidental: Deceased was on route to a fire when he fell out of the truck in to on coming traffic. He did not have his seatbelt on at the time.*	*1. The exemption as it relates to firefighters in Manitoba regulation 421/87, be removed after adequate notice is given to all fire departments in the Province of Manitoba and that thereafter all fire fighters be required to use seatbelts in their moving vehicles.* *2. The Fire Departments throughout the Province of Manitoba again instruct and periodically re-instruct fire fighters that they are to remain seated and use their seatbelts anytime the fire truck is enroute to or from a fire scene.*
10. Hanging	*Suicide: Deceased was an inmate at the Provincial Remand Centre when he was found hanging by the neck by means of a towel.*	*1. That a camera be installed that will provide for complete surveillance of the interior of cell #8.* *2. That viewing ports be installed in the solid steel walls in the area of cell #8 so that patrolling officers can see into cell #8 from both sides and that all blind spots are eliminated in that area.* *3. That all cameras and monitors in B Block be*

Case	Description	Judicial Recommendations
		checked to ensure that proper surveillance is provided of all areas and that all blind spots, if any, are eliminated by repositioning the cameras or installing additional cameras. *4. That the cameras and monitors be checked to ensure that high quality pictures are provided to the officers in control.* *5. That consideration be given to the specific placement of inmates with suicidal tendencies in certain cells in B Block. It may be that certain suicidal inmates could be placed in a four bed cell or in a cell where a suicidal inmate is in the midst of activity and not off by himself.* *6. That the bar across the top of the shower be eliminated.* *7. That a physical survey of B Block be conducted by experienced personnel with a view to eliminating blind spots and increasing suicide prevention. These persons should not be from the P.R.C. in order to provide a fresh perspective.* *8. That the branch policy on Suicide Prevention be implemented as soon as possible.* *9. That when Control is staffed by only one control officer (after normal hours), a second officer is present to view the CCTV monitors when the control officer is occupied with the documentation or other duties that distract from the viewing of the CCTV monitors.*
11. Crushing injury to the head	*Accidental: Deceased was driving a steel roller for the Department of Highway when it rolled off the shoulder in to the ditch, tipping over onto the deceased in the process.*	*1. The implementation and enforcement of The Construction Industry Safety Regulations under Workplace Safety and Health Act, (CCSM W210) passed May 1, 1991, and relating to rollover protective structures, proceed as expeditiously as possible.* *2. That all Department of Highways equipment manufactured prior to January 1, 1979 which is subject to a rollover hazard, and which is capable of being equipped with rollover protective structures and seat belts, be so equipped wherever possible, and as soon as possible.* *3. That static guide rollers, and all equipment subject to a rollover hazard, which is not capable of being retrofitted with rollover protective structures, should be phased out and*

Case	Description	Judicial Recommendations
		replaced by the Department of Highways as quickly as possible. *4. That the "safe operating check list" with written proficiency verification continue to be utilized by the Department of Highways as a means of verifying and ensuring that each employee has received basic safe operating instructions prior to operating any department machinery.* *5. That the system of designated trainers commenced by the Department of Highways be put into place as an aspect of developing more extensive equipment operator training and certification programs* *6. That directives be issued to departmental employees requiring operators of units with rollover protective structures to wear their seat belts at all times, and further advising that there will be enforcement by supervisory personnel regarding the use of seat belts, with progressive disciplinary action for failure to wear the belts.*
12. Asphyxia	*Accidental: Deceased was attending a camp for the severely disabled children, when in the morning, her body was found partially out of bed and suspended by her head which was caught between the mattress and the bed frame rail. Resuscitation was unsuccessful.*	*1. That immediate action be taken by the federal government to regulate the design and construction of medical devices. No bedrails should be manufactured and/or offered for sale, unless they are designed in such a fashion so as to ensure the horizontal bars of the side rails extend fully to each end of the bedrail unit itself.* *2. Those responsible for the drafting of standards relating to medical devices are called upon to reassess the minimum distances that should be permitted to exist between the horizontal bars and the side rails with an eye to ensuring that the gaps between these rails are sufficiently limited so as not to represent a potential for danger even in the smallest user of same. Of the utmost importance in the reassessment of these dimensions is the necessity to ensure that the bottom side rail is designed in such a fashion so as to preclude the possibility to being a gap between it and the top of the mattress to which it is attached, of such size as to permit any portion of even the smallest user to slip between this space.* *3. It is recognized that the bedrail being referred to in the above recommendations are designed primarily for use in small institutions with limited*

Case	Description	Judicial Recommendations
		budgets or for domestic use, and are not intended to be permanently attached to bed-frames. These less expensive bedrails are affixed to beds by adjustable bars which pass under the mattress and into which the side rails of each side of the bed are placed. The portion of the bedrail assembly which passes under the mattress are adjustable, so they can fit beds of varying widths, and similarly the vertical tubing at each end of the portion of assembly is designed in such a way so that the side rails which fit into them can be raised and lowered. It is essential that the mechanical devices which permit the adjustments referred to, be of sufficient substance so as to ensure that they cannot fail and thus create, in the case of the bars that go under the mattress, a potential for a gap to open between the side of the mattress and the side rails, and in the case of the side rails themselves, to ensure that they do not accidently fall, allowing the user of the bed to roll of same. *4. That every bedrail of the type described above be sold with detailed instructions as to there assembly and usage, and with a warning as to the limitations of their use, particularly when it is intended that same be used on beds that youngsters will be placed. These regulations ought to include a provision which prohibits the transfer of possession of such rails in after-sale circumstances, unless accompanied by the aforementioned instructions and warnings. It is appreciated that enforcement of such a provision would present its own problems, but awareness of a limited number of consumers is a step in the right direction.* *5. That federal and provincial governments commence with appropriate haste to advise manufacturers of such rails of the design faults inherent in there products, and that voluntary action be requested to either cease production of such rails, or resolve the defect in them until such time that the appropriate regulations can be enacted.* *6. That the camp clearly obtain in writing the camper's needs and preferences, and to particularize how these campers respond to strangers and new surroundings.* *7. That camp administration make it clear to parents or guardians of campers that even if*

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		their child or ward attended camp on a previous occasion that the current application form must contain all the information from the earlier form, along with appropriate updating the same. *8. That information regarding campers be bestowed to the counsellors who are responsible for the campers day-to-day safety. Though privacy is important, the administration should take honesty and integrity into the hiring of staff.* *9. That the counsellors be trained with respect to all medical devices that are to be utilized with in the camp. There should be a policy with regards to all counsellors know the use and limitations of the equipment, not on a as required basis.* *10. That a communication system be placed between the cabins and the halls. The system should be a non-intrusive system for communicating between the areas of camp if an emergency should arise.* *11. That the camp administration not rely on the other campers to communicate problems or potential dangers. Particulary at night, supervisory staff provide for some level of bed checking. This ought to take the form of some consistent policy.*
13. Multiple injuries	*Suicide: Apparent suicide as a result of jumping from the water tower located on the grounds of the Selkirk Mental Hospital Complex. The deceased was a patient of the hospital.*	*1. Designated hospital beds along with psychiatric nursing staff in The Pas Health Complex for psychiatric patients. It is not suggested these be long term care beds, but merely to respond to immediate crisis intervention that requires short term constant monitoring until stability is achieved and community-based treatment, if appropriate, can be implemented.* *2. Psychiatrists or psychiatrically trained assessment personnel available at the complex, or at the very least, means of immediate availability to a psychiatrist to provide expertise and advice as to crisis intervention.* *3. The availability of a twenty-four hour multidisciplinary response team to crisis intervention to respond to mental health crisis. The team would be comprised of medical, psychiatric personnel, community health workers, social workers, care-givers and family members who would have various degrees of training and mental health expertise in community response. The location components and control of such*

Case	Description	Judicial Recommendations
		service would vary according to the needs of the patient and the needs of the community. The key factors, however, must be availability of personnel and resources and training in the field of psychiatric care. *4. An on going and strengthening relationship between the general hospital and the mental health system. This is necessary not only from the point of view of medication, but from the point of view that most success will be derived from integrated, consultative approach to the individual's treatment. An important off-shoot of this approach should be sharing of training and expertise in the mental health field.* *5. The development and strengthening of case management in these cases, the management of such a case requires some team member to be in charge in order to co-ordinate assessment consultation, treatment needs, treatment monitoring, and collection of information and education surrounding the patient.* *6. Long term rehabilitation/continuing care resource has to be developed. Needless to say this is an extremely difficult and complex issue but without effort in the rehabilitation area, long term success appears to be minimal. This would appear to require the education, co-operation and collaboration of the entire community in the treatment of the mentally ill.*
14. Multiple injuries from fall	*Accidental: Deceased was an employee of Heli-Fab Ltd. when he fell 3 feet from a table and at about the same time a housing fan fell from the same table. Deceased's death was caused by his head hitting one or both of the welding machines near the table he fell from, and/or the concrete floor.*	*None.*
15. Crushing injuries	*Accidental: Deceased was working on the 2400 foot level as a switchman at the INCO T3 mine when the crosscut*	*1. That all switchmen should stand on the far side of the intersection when signalling a train to proceed.* *2. That signal lights are to be installed that are*

Case	Description	Judicial Recommendations
	train ran into the T3 train which caused the crosscut train to derail and the leading car jumped the track and crushed the deceased.	*clearly visible to the train engineers. The light controls operated by the switchmen are to be located on the far side of the intersection.*
16. Multiple injuries	*Accidental: Deceased was a passenger in a vehicle travelling along Highway #200 when it lost control, rolled over while expelling the passenger into a nearby field.*	*None.*
17. Multiple injuries	*Accidental: Deceased was a long-term in-patient of the Grace Hospital Psychiatry. When found he was locked in a bathroom unconscious. He was known to have a habit of stuffing food in mouth. He had no significant medical history.*	*Not Available.*